88-342

No. 88.....

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In the Supreme Court
OF THE
United States

OCTOBER TERM 1988

SUNSHINE HEALTH SYSTEMS, INC.
Plaintiff,

VS.

OTIS R. BOWEN,
Defendant.

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

case presents a fiscally important, somewhat but conceptually very simple issue of statutory ction. How that issue is resolved determines and to what extent litigated retroactive Medicare rsement adjustments bear interest, and thus to xtent mistakes in reimbursement determinations te interest-free loans to or from the government.

uestion presented by this petition is: For hospital re reimbursement adjustments made as a result ns brought under 42 U.S.C. § 1395oo(f)(1), is gment interest prescribed by 42 U.S.C. o(f)(2)? If so, does 42 U.S.C. § 1395oo(f)(2) h a single reference rate for prejudgment interest providers, or a multiplicity of rates for differently l providers?

decision of first impression among the circuits and s, the Ninth Circuit in effect held that the statute a multiplicity of rates as to differently situated rs, and that for any action filed in district court ctober 1, 1989, no interest is payable either to the nent or to any prevailing hospital following appeal e Secretary's decision.

ioner Sunshine Health Systems, Inc. ("Sun- contends that the statute fixes a single reference interest as to all providers, which rate is equal to of return on equity allowed as reimbursement to nursing facilities.

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OCTOBER TERM 1988

SUNSHINE HEALTH SYSTEMS, INC.
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ETITION FOR WRIT OF CERTIORARI

DICTIONAL GROUNDS FOR THIS PETITION

petition is submitted pursuant to 28 U.S.C. e). The decree sought to be reviewed was issued ered by the Ninth Circuit March 22, 1988. A duly tition by Sunshine for rehearing was denied 1988.

STATUTES AND REGULATIONS

1395oo (f) (2)

Where a provider seeks judicial review pursuant to ph (1), the amount in controversy shall be subject al interest beginning on the first day of the first eginning after the 180-day period as determined

uant to subsection (a) (3) of this section and equal to
rate of return on equity capital established by regula-
pursuant to section 1395x(v) (1) (B) of this title and
ffect at the time the civil action authorized under
graph (1) is commenced, to be awarded by the
ewing court in favor of the prevailing party.

JSC 1395ww(g) (2)

2) (A) The Secretary shall provide that the amount
h is allowable, with respect to reasonable costs of
tient hospital services for which payment may be
e under this subchapter, for a return on equity capital
nospitals shall, for most reporting periods beginning
r after April 20, 1983, be equal to amounts otherwise
vable under regulations in effect on March 1, 1983,
pt that the rate of return to be recognized shall be
l to the applicable percentage (described in subpara-
h (B)) of the average of the rates of interest, for
of the months any part of which is included in the
rting period, on obligations issued for purchase by
Federal Hospital Insurance Trust Fund.

B) In this paragraph, the "applicable percentage" is

(i) 75 percent, for cost reporting periods beginning during fiscal year 1987,

(ii) 50 percent, for cost reporting periods beginning during fiscal year 1988,

(iii) 25 percent, for cost reporting periods beginning during fiscal year 1989, and

(iv) 0 percent, for cost reporting periods beginning on or after October 1, 1989.

STATEMENT OF THE CASE

nshine commenced an action in February 1985, 42 U.S.C. § 1395oo(f)(1), to challenge the Secre- ruling which designated plaintiff Sunshine as a hospital" for purposes of Medicare reimbursement the Prospective Payment System ("PPS"). Plain- nshine prevailed before both the district court and inth Circuit in its contention that the "new hospital" nation was erroneous and that Sunshine was entitled ejudgment interest on resulting retroactive reim- ment adjustments. As a result, Sunshine received a nent for additional Medicare reimbursement for years, and for prejudgment interest thereon.

nshine and the Secretary, however, disagreed about nterest rate payable under the statute, 42 U.S.C. 5oo(f)(2). Sunshine contended that the statute as a reference rate for interest the rate equal to the n on equity allowed as reimbursement to skilled ng facilities, and that the rate of prejudgment inter- r all providers, hospital and non-hospital, proprie- nd non-proprietary, whether under PPS or the older ased reimbursement system, is equal to that refer- rate. The Secretary contended that the statute fixed nce rates equal to the rate of return on equity, if *llowed to each particular provider*, so that the rate ejudgment interest for each kind of provider, and system of reimbursement, *is different*. The district adopted Sunshine's position, but was reversed by Ninth Circuit, which adopted the Secretary's ntion.

ARGUMENT

I.

Statute Fixes A Single Reference Rate For All oviders and for the Government

e issue is simply how to construe the statute. An nation of the proper construction, as presented to ccepted by the district court, follows.

e applicable rate of interest is specified by 42 U.S.C o(f)(2) as the rate "equal to the rate of return on y capital established by regulation pursuant to Sec- 395x(v)(1)(B) of this title and in effect at the time civil action authorized under paragraph 1 is lenced."

will be shown below, Part II, the Ninth Circuit eously construed this statutory language as though d: "equal to the *affected provider's* rate of return on y capital established and in effect at the time the action authorized under paragraph 1 is commenced."

e regulation that allows reimbursement of an im- return on equity capital is 42 C.F.R. § 413.157 erly § 405.429) (CCH Medicare and Medicaid e, ¶ 20,887.157). Tables of rates are published in the der Reimbursement Manual, at PRM-1 § 1206 (CCH 2), which contains two series of tables, one marked inpatient hospital services only," and one marked ot use for inpatient hospital services." Contrary to one might intuitively expect, the series which is able to the judgment in this case, and in all cases, is *tter* series, the one applicable to *non-hospital* provid- ncluding skilled nursing facilities. This becomes ent from the cross-reference specified by 42 U.S.C. o(f)(2).

cross-referenced subsection, 42 U.S.C. 1395x(v)
, provided as follows:

uch regulations in the case of extended care ser-
es furnished by proprietary facilities shall include
visions for specific recognition of a reasonable
urn on equity capital, including necessary working
ital, invested in the facility and used in the
nishing of such services, in lieu of other al-
ances to the extent that they reflect similar terms.
e rate of return recognized pursuant to the preced-
sentence for determining the reasonable cost of
services furnished in any fiscal period shall not
eed 1½ times the average of the rates of interest
each of the months any part of which is included
such fiscal period, on obligations issued for
chase by the Federal Hospital Insurance Trust
nd."

Consolidated Omnibus Budget Reconciliation Act,
99-272 Section 9109 (100 Stat. 161) reduced the
uoted maximum rate of return for cost reporting
beginning on or after October 1, 1985, to the
Hospital Insurance Trust Fund ("FHIT Fund")
on rate. For the cost reporting period relevant to
e, however, January 24, 1985 through January 23,
e applicable rate limit was 1½ times the FHIT
ate.

dingly, the statute fixes a prejudgment interest
ual to the rate of return on equity allowed as
sement for "extended care services furnished by
ary facilities." Section 1395x(h) defines extended
vices as certain items and services "furnished to
ient of a skilled nursing facility." The statute is
erefore, that an extended care facility is a skilled
facility, *not a hospital*. This fact is important.

The above-quoted portion of Section 1395(x)(v)(1)(B) was added by Public Law 89-713 (80 Stat. 1111). The Conference Committee Report which accompanied the amendment clearly indicates that it was intended to authorize and direct the Secretary to publish by regulation a rate of return applicable to skilled nursing facilities providing extended care. See Conf. Rep. No. 2317, 89th Congress, 2d Sess. 166 reprinted in 1966 U.S. Code Cong. Admin. News 3692-93. The Conference Committee Report clearly distinguishes between skilled nursing facilities and hospitals. It specifically notes that the Conference Committee expected the Secretary to apply "similar or comparable principles" (not the new statute) in determining reasonable costs for reimbursing proprietary hospitals. Clearly, then, Congress affirmed that this amendment was specifically directed at skilled nursing facilities.

In 1983, Congress fixed reimbursement for imputed return on equity capital for hospitals by enacting another statutory provision, 42 U.S.C. 1395ww(g)(2)(A), which provides in pertinent part that: "The Secretary shall provide that the amount which is allowable . . . for a return on equity capital for hospitals" shall be as provided by "regulations in effect March 1, 1983" until fiscal 1987, and thereafter shall be phased out. Pub. L. 98-21, § 601 (97 Stat. 162).

Neither in 1983 nor thereafter did Congress add as an additional cross-reference in Section 1395oo(f)(2) the new provision governing return on equity for hospitals, 1395ww(g)(2). This was not a Congressional blunder or oversight.

From all of the above it is plain that the two series of rate tables published are authorized by separate statutory provisions, namely Sections 1395(x)(v)(1)(B) (skilled

ng facilities), and 1395ww(g)(2)(A) (hospitals), nat the table which Section 1395oo(f)(2) requires be to compute interest on the judgment is the one for d nursing facilities, at CCH ¶ 5782, pages 1917-19. nine's action was filed in February 1985. The applica-te is therefore at Column G, line 7; this is the rate eable to a cost report period the first full month of is February 1985, and which ends on January 1986. rate is 15.873 percent.

ordingly, this court should reverse the order of the Circuit dated May 10, 1988, which erroneously ed interest calculated at the rate equal to the hospi-turn on equity for such period, 10.583 percent.

II.

Ninth Circuit's Decision That A Multiplicity Of es Are Prescribed Is Erroneous

e heart of the Ninth Circuit's decision, and the heart error, is its declaration that congressional intent to *inextricably* [emphasis added] link the calcula-f interest with that provided for the return of equity l." The Ninth Circuit panel, however, apparently ed the fact that present law when fully implemented *nates* all reimbursement payments to hospitals for eturn on equity capital. The Ninth Circuit decision therefore, that as of October 1, 1989, the rate of st payable drops to zero for all hospitals, as well as ne government. The rate of return on equity, ex-ed as a percentage of the FHIT Fund obligation ge interest rate, is 50% during fiscal year 1988, to 25% in fiscal 1989, and to zero on October 1, (Section 1395ww(g)(2)(B)). As to nonprofit hospi-he payable rate is already zero.

It is impossible to determine from the Ninth Circuit opinion whether this and other anomalous results were intended, but they are unavoidable. Here are a few of such anomalous results. For cases filed on July 1, 1989, by a nonprofit hospital, regardless of the outcome of the litigation, neither the hospital nor the government will be entitled to interest. For a case filed July 1, 1987, by a proprietary hospital, however, either the government or the hospital, whichever prevails, will be entitled to interest at 25% of the FHIT Fund obligation average. For cases filed on or after October 1, 1989, neither the proprietary hospital nor the government will be entitled to any interest in any event. Skilled nursing facility providers, however, are still entitled to interest at the full FHIT Fund average rate.

Further, in cases filed by nonprofit hospitals, neither the hospital nor the government has ever been entitled to any interest under the statute.

In summary, the Ninth Circuit decision creates a crazy quilt of irrational results, totally at odds with the explicit language of the statute.

The only way that such anomalous and illogical results can be avoided is to follow the letter of the statute, which uses as a reference rate the allowed rate of return on equity for skilled nursing facilities, which rate remains a percentage equal to the average interest rate on FHIT Fund obligations.

The Ninth Circuit panel appears to have believed that use of the skilled nursing facility rate of return on equity as a reference rate somehow impugned the validity of either Section 1395ww(g)(2), the phase-out provision for hospital return on equity, or the accompanying regulation implementing it. Such assumption, however, is unwar-

The purpose of that subsection (g)(2) is to whether and to what extent a provider can be rsed for an imputed return on invested capital. a different and unrelated question from whether a successful litigant in a reimbursement dispute o receive interest on the amount ultimately recov- he court seems to have assumed that literal co- ce of Section 1395ww(g)(2) and Section (f)(2) is impossible. That is plainly not the case, r, as the district court well understood.

rationale for phase-out of the return on equity is PPS is not intended to reimburse each hospital's costs, but to set a market price for Medicare l services and create an incentive for the Medicare r to structure its operations such that it can make , or at least survive, on that fixed market price. he PPS system is fully implemented, the reim- ent rates are uniform for each provider within the If a provider makes a profit on those rates, well od. If a provider cannot sustain itself with those hen the provider should either become more effi- go out of business. Such is the theory behind the tem.

rdingly, reviewed properly, the statutory provision rn on equity which so concerned the Ninth Circuit s a disappearing vestige of the superseded cost- eimbursement system. By contrast, the question of and to what extent interest shall be payable on nts of district courts resulting from reimburse- sputes is a continuing issue under both the cost- eimbursement system and the PPS.

III.

overeign Immunity Is Not Relevant To This Issue

For at least two reasons, the concept of sovereign mmunity, relied upon heavily by the Secretary in this ontroversy, is totally irrelevant to its resolution. First, here is no doubt that the statute explicitly calls for terest to be paid; the issue is simply how best to terpret the language consistently with other Medicare ws and regulations. Second, as the language of the atute makes clear, it is a bilateral provision, which ovides interest to the prevailing party. Where the gov-rnment is the prevailing party, it is entitled to interest nder the statute. The Ninth Circuit opinion makes the overnment as well as the provider ineligible to recover terest as a prevailing party in such a dispute.

IV.

here Is No Administrative Interpretation Or Practice To Which a Court May Defer In This Matter

Nor is this a case where there is any administrative terpretation or practice which deserves the deference of e courts. In fact, as this case illustrates, the Secretary d not have an administrative practice with respect to is matter. In this case, the original judgment required e Secretary to pay interest on a specified amount covered by the judgment, as required by law. The fiscal termediary at first paid interest at a rate of 9%, which e Secretary always conceded was improper. Nor did the ecretary ever introduce any evidence of any administra-ve policy with respect to this issue. The Secretary has ever adduced any evidence, for instance, of a practice of ot charging nonprofit hospitals any interest on judg-

overed under the statute, nor of failing to pay
o such providers where the provider prevails.

hout this litigation, the Secretary has failed to
he implications of his present position. Never,
ce, has the Secretary acknowledged that under
retation there is *no interest* payable to either the
nt or nonprofit hospitals in disputes involving
hospitals.

, the Secretary's present position is actually
the Secretary's own recognition that interest is
overpayments and underpayments. Administra-
ermined underpayments and overpayments rou-
r or include interest under 42 C.F.R. § 405.376.
there is no reason why, if the same administra-
ermined adjustment is litigated, the resulting
whether for the hospital or the government,
shorn of interest.

V.

n Circuit Decision Will Hamper Resolution Of ursement Disputes

y the worst effect of the Ninth Circuit decision
certainty it creates. Because the decision is
o vulnerable is but the first circuit or district
n the issue, its potential for harm is great.

S has been in effect since late 1983 but only now
Notices of Program Reimbursement being issued
he initial fiscal year of PPS. Many determina-
ting to base-year calculations will result in
e reimbursement adjustments going back sev-
. Whether interest is available over those years
very important question. Confused case law on
ct will obviously impede expeditious and fair

resolution of such controversies. An authoritative disposition of the issue by this Court will obviously promote such resolution.

Another obvious area in which the Ninth Circuit's decision has a potentially major effect is the reimbursement of malpractice insurance premiums under cost-based reimbursement, which has been the subject of several years of litigation. That litigation culminated in a new regulation promulgated in 1986, 42 C.F.R. § 413.56, which, subject to the rules of administrative finality and reopening, applies retroactively to cost reporting periods beginning on or after July 1, 1979. The Secretary and provider hospitals are trying to settle those retroactive adjustments, as to which interest is a very large component. The Ninth Circuit opinion creates substantial uncertainty as to whether or when interest is payable on such adjustments. Authoritative resolution of this issue by the Court will be beneficial to all concerned.

VI.

CONCLUSION

For all of the foregoing reasons, petitioner respectfully submits that its petition for certiorari should be granted.

Respectfully submitted,

SHEA & GOULD

By _____
Thomas J. Weiss
Attorneys for Petitioner

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APPENDIX A

SUNSHINE HEALTH SYSTEMS, INC.,
dba Christian Hospital Medical
Center, Plaintiff-Appellee,

v.

Otis R. BOWEN, Secretary of the
Department of Health and Human
Services, Defendant-Appellant.

No. 87-6065.

United States Court of Appeals,
Ninth Circuit.

Argued and Submitted February 4, 1988.

Decided March 22, 1988.

As Amended May 10, 1988.

etary of Department of Health and Human Ser-
ppealed from judgment of the United States Dis-
Court for the Central District of California,
arie H. Stotler, J., awarding interest to proprietary
l at rate of 15.875% after hospital successfully
ged Secretary's designation of hospital as a "new"
l for purposes of medicare reimbursement. The
f Appeals, Ferguson, Circuit Judge, held that rate
est payable to proprietary hospital following judi-
iew of administrative decision of Medicare's Pro-
eimbursement Review Board was rate of return on
capital, rather than one and one-half times that

rsed and remanded.

Fan, Asst. U.S. Atty., Los Angeles, Cal., for defen-
ppellant.

Thomas J. Weiss, Shea & Gould, Los Angeles, Cal., for plaintiff-appellee.

Appeal from the United States District Court for the Central District of California.

Before ALARCON, FERGUSON and BEEZER, Circuit Judges.

FERGUSON, Circuit Judge:

The Secretary of the Department of Health and Human Services ("Secretary"), appeals the district court's amended final judgment awarding interest to Sunshine Health Systems, Inc. ("Sunshine"), at the rate of 15.875 percent. The Secretary argues that this interest rate is inapplicable to proprietary hospitals such as Sunshine, and that the proper interpretation of the statutory provision requiring payment of interest requires calculation at the rate of 10.583 percent. We agree.

I.

Sunshine originally brought suit against the Secretary, challenging its designation of Sunshine as a "new" hospital for purposes of Medicare reimbursement during the transition period from Medicare's old cost-based system to its new fixed payment system. The district court agreed with Sunshine, ordered reimbursement under the interim payment system and further ordered that interest be paid at the rate "required by law." This Court then affirmed the district court's decisions, ordering interest to be calculated pursuant to 42 U.S.C. § 1395oo(f)(2). *Sunshine Health Systems, Inc. v. Bowen*, 809 F.2d 1390, 1399 (9th Cir.1987). The district court subsequently amended its original order, awarding the payment of interest at the rate of 15.875 percent.

ecretary then filed this appeal, contending that
rict court's reading of these provisions was in
d that the proper rate of interest for proprietary
, such as that operated by Sunshine, is only
ercent.

ve jurisdiction pursuant to 28 U.S.C. § 1291.

II.

l to our decision is the legislative history of the
y and regulatory enactments addressing interest
s and return on equity capital. We address this
e history first, and then consider its application
sues raised on appeal.

A.

.C. § 1395oo(f)(2), enacted in 1974, authorizes
ent of interest where a party has sought judicial
f an administrative decision of Medicare's Pro-
imbursement Review Board ("PRRB"). It pro-
at interest shall be paid at a rate "equal to the
eturn on equity capital established by regulation
to section 1395x(v)(1)(B) of this title and in
the time the civil action authorized under para-
) is commenced," and that the interest is to be
by the reviewing court "in favor of the prevailing

n 1395x(v)(1)(B), originally enacted in 1966,
for reimbursement of the reasonable cost of

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t is based on the amount of reimbursement in dispute, and
the first day of the first month beginning after the 180-day
determined pursuant to subsection (a)(3) of this section
.S.C. § 1395oo(f)(2).

extended care services provided by proprietary facilities under Medicare. This figure was meant to include return of equity capital at a rate not to exceed one and one-half times the average rates of interest for certain specified debt obligations.[2]

The phrase "extended care services" is defined in 42 U.S.C. § 1395x(h) as referring to various items and services furnished by a skilled nursing facility to an inpatient of that facility, and does not include inpatient hospital services provided by proprietary hospitals, such as Sunshine. Thus, this definition left Sunshine ineligible for a return on its equity capital under section 1395x(v)(1)(B).

However, the legislative intent at the time section 1395x(v)(1)(B) was enacted was that "similar or comparable principles in determining reasonable costs for reimbursement of proprietary hospitals" by applied by the Secretary. See Conf.Rep. No. 2317, 89th Cong., 2d Sess. 166, *reprinted in* 1966 U.S.Code Cong. & Admin.News 3676, 3692-93. Thus, in conformance with congressional intent, the Department of Health and Human Services ("HHS") issued 42 C.F.R. § 405.429(a)[3], which provided for a return on equity capital to *all* proprietary providers, both skilled nursing facilities providing extended care

[2]Section 1395x(v)(1)(B) provides in relevant part:

> Such regulations in the case of extended care services furnished by proprietary facilities shall include provision for specific recognition of a reasonable return on equity capital .... The rate of return ... shall not exceed one and one-half times the average of the rates of interest, for each of the months any part of which is included in such fiscal period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

[3]This regulation was redesignated on September 30, 1986. See 51 Fed.Reg. 34790 (1986). It is now located at 42 C.F.R. § 413.157.

and proprietary hospitals furnishing inpatient services. The rate of return for all providers was percentage equal to *one and one-half times* the of the rates of interest on certain public debt ns.

se comes before us due to legislation enacted in U.S.C. § 1395ww, which established the Prospec- ment System ("PPS") for inpatient hospital provided by proprietary hospitals. Rather than ng providers on a cost basis for health care PPS allows providers to be paid prospectively on of predetermined rates for services. Subsection the PPS statute provides for reimbursement to ry hospitals of equity capital, and requires that tary promulgate regulations allowing such re- uity capital at a rate *equal* to the average of the nterest on certain debt obligations.[4]

ng enactment of section 1395ww(g)(2), in 1983 mended its prior regulation, 42 C.F.R. (a), originally enacted under section 1)(B). The amendment created a distinction proprietary hospitals and other proprietary prov- ering inpatient hospital services in the rate of equity capital to which each was entitled. As regulation 405.429(a)(1)(iii) set the rate of r proprietary hospitals at a rate *equal* to the f specified interest rates. In contrast, regulation .)(1)(ii) kept the rate of return for all other ry providers (such as skilled nursing facilities

---

1395ww(g)(2) does not address or alter the return on tal allowed under section 1395x(v)(1)(B) for extended es provided by skilled nursing facilities.

offering extended care), at *one and one-half times* the average rates.[5]

In its amended order dated April 20, 1987, the district court awarded interest to Sunshine at the rate of 15.875 percent, using the one and one-half factor. The court's award was based on its interpretation of 42 U.S.C. §§ 1395oo(f)(2) and 1395x(v)(1)(B), 42 C.F.R. § 405.429, and a "Table of Interest Rates for Proprietary Provider's Return on Capital for Other Than Inpatient Hospital[s] July 1985 through June 1986."[6]

B.

The Secretary argues that Congress intended that the rate of interest payable following judicial review of PRRB decisions match the rate of return of equity capital. Moreover, the Secretary contends that, although the regulation in effect in February 1985 had been amended pursuant to section 1395ww(g)(2), rather than subsection x(v)(1)(B), application of the amended regulation is nevertheless in accordance with a reasonable interpretation of section 1395oo(f)(2), and is consistent with that section's underlying purpose.

---

[5]Subsequently, in 1986, section 1395x(v)(1)(B) was amended, setting the rate of return on equity capital for extended care services at a factor of one, conforming it with the rate allowed for proprietary hospitals. Sunshine filed its action seeking reimbursement of monies expended providing Medicare services on February 8, 1985, fourteen months prior to this amendment of section 1395x(v)(1)(B).

[6]There is no indication by the district court which would explain its reliance on the table referred to in the amended order, and it appears wholly irrelevant to a determination of the proper rate of interest for Sunshine, an inpatient hospital. Moreover, the rate of interest at issue is that which was in effect on February 8, 1985 — a date not included in the table.

e regulations of the Secretary must be interpreted in
of the governing statutes, and must be consistent
and in furtherance of the purposes and policies
died therein. *Pacific Coast Medical Enterprises v.*
is, 633 F.2d 123, 131 (9th Cir.1980). In construing
Iedicare statutes, some deference is to be given to
nterpretation of the agency charged with the admin-
ion of those statutes. *Regents of University of Califor-*
. Heckler, 771 F.2d 1182, 1187 (9th Cir. 1985).
ever, deference to the Secretary must yield to the
meaning of the statute as revealed by its language,
ose and history. *Southeastern Community College v.*
, 442 U.S. 397, 411, 99 S.Ct. 2361, 2369, 60 L.Ed.2d
1979).

rough the Medicare Act of 1965, "Congress made
its intent that providers were to be reimbursed, as
y as possible, for all costs necessarily incurred in the
ent delivery of health care services to Medicare
iciaries." *Regents,* 771 F.2d at 1188. The Senate
rt accompanying the Act elaborated on this Congres-
l intent by noting that reimbursement under section
should "approximate as closely as practicable the
l cost (both direct and indirect) of services ren-
l to the beneficiaries of the program . . . ." S.Rep. No.
89th Cong., 1st Sess., reprinted in 1965 U.S. Code
. & Admin.News 1943, 1976. Included in this eco-
e cost is equity capital invested in the facility for the
shing of services. Conf.Rep. No. 2317, 89th Cong., 2d
166, reprinted in 1966 U.S. Code Cong. & Ad-
News 3676, 3692.

including a provision for the return of equity capital
oprietary facilities, Congress in effect authorized the
ursement of profit that would have accrued had the
ties been providing services not covered by Medi-

care. This provision thus facilitates a more accurate approximation of a provider's actual cost of providing Medicare services.

Sunshine suggests that the return of equity capital and payment of litigation interest need not be treated similarly, and thus, different methods of calculation may be used for each. Yet it also concedes there is no basis in logic or precedent for this construction.

The provision of interest after judicial review of reimbursement decisions by the PRRB serves Congress' expressed purpose of reimbursing as closely as possible the actual cost of providing Medicare services. Subsection 1395oo(f)(2) specifically states that interest shall be "*equal to the rate of return on equity capital* established by regulation pursuant to section 1395x(v)(1)(B) . . . ." (emphasis added.) This reference to the only statute then in effect relating to the return of equity capital clearly indicates Congress' intent to inextricably link the calculation of interest with that provided for the return of equity capital. Such a construction is logical because it leaves health care providers who prevail following judicial review of Medicare decisions in the same position they would have been in the absence of such review.

Section 1395oo(f)(2) requires that the rate of interest be equal to the rate of return of equity capital specified in regulations promulgated under section 1395x(v)(1)(B). While section 1395x(v)(1)(B) applied only to skilled nursing facilities, the regulation adopted in 1982, 42 C.F.R. § 405.429, encompassed, consistent with Congress' express intent, proprietary hospitals as well. However, because of the distinction section 1395ww(g)(2) makes between proprietary hospitals and other providers, its

ıent required the amendment of regulation 405.429
t regulation relates to proprietary hospitals.[7]

shine seems to believe that because the 1983
ment of regulation 405.429 was made pursuant to
ı 1395ww(g)(2), rather than section
v)(1)(B), the amendment should be disregarded
applicable to this case. However, the effectiveness
amendment to a regulation does not depend on the
es for which a party refers to that regulation.
, its validity depends — like the validity of any
tion — on (1) whether it exceeds the scope of the
ity pursuant to which it is promulgated,[8] (2)
er it is arbitrary, capricious, an abuse of discretion,
erwise not in accordance with the law, and (3)
er proper procedures were followed in its issuance.
een State College v. Cleland, 621 F.2d 1002, 1009
ir.1980) (*citing Citizens to Preserve Overton Park,*
Volpe, 401 U.S. 402, 415-17, 91 S.Ct. 814, 823, 28
d 136 (1971)). There has been no contention that
ıendment fails in any of these areas. If this court
disregard the amendment as Sunshine would like,
sult would be to render section 1395ww(g)(2)

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hine argues, however, that if Congress intended the amended
on to apply to the payment of interest, it could have amended
1395oo(f)(2) to include a reference to the 1983 PPS legisla-
d its effect on the rate of return of equity capital for
ary hospitals. However, there was no need for Congress to so
section 1395oo(f)(2). *United States v. Fausto*, — U.S. — , 108
8, 676, 98 L.Ed.2d 830 (1988) (The "classic judicial task of
ing many laws enacted over time . . . necessarily assumes that
lications of a statute may be altered by the implications of a
atute.") It is sufficient that section 1395oo(f)(2) identifies
vant regulation for determining the proper rate of interest.

language of the amendment is nearly identical to the mandate
on 1395ww(g)(2).

ineffective — a result which is extreme, unnecessary and unwarranted. *See Ruckelshaus v. Monsanto Co.*, 467 U.S. 986, 1018, 104 S.Ct. 2862, 2880, 81 L.Ed.2d 815 (1984) (where two statutes are capable of coexistence, the courts must regard each as effective in the absence of a clearly expressed congressional intent to the contrary.) In addition, such a notion violates established principles of statutory construction. *See e.g., FMALI Herb, Inc. v. Heckler*, 715 F.2d 1385, 1387 (9th Cir.1983) (regulations implementing a statutory mandate "have the force and effect of legislation, and may not be set aside because a court would have read the statutory mandate differently."); *Montgomery Ward & Co., Inc. v. F.T.C.*, 691 F.2d 1322, 1329 (9th Cir. 1982) (an amendment is proper "when adequate notice is provided to affected parties pursuant to appropriate rule-making procedures.") Moreover, such a construction lies in direct conflict with Congress' express intent in this area.

In enacting the Prospective Payment System under section 1395ww, Congress re-evaluated the actual cost to proprietary hospitals of providing Medicare benefits. Evidently, Congress determined that a factor of one in calculating a proprietary hospital's return on equity capital, and the payment of interest tied to that return on equity capital, resulted more closely in the reimbursement of actual costs of providing Medicare benefits. This culminated in the enactment of subsection (g)(2), and ultimately led to the amendment of 42 C.F.R. 405.429.

The regulations currently in effect were originally promulgated pursuant to section x(v)(1)(B) and as amended are sufficient for the purposes of litigation interest calculation. At the same time, they are consistent with the Congressional mandates of section ww(g)(2) for calculation of return of equity capital.

s, the interpretation of section 1395oo(f)(2) and
ccompanying disregard of the amended form of
tion 405.429 urged by Sunshine and adopted by the
et court, do not square with the intent of Congress
opting the provisions relevant to this dispute.

III.

s stretching beyond the limits of literal construction
d that the regulations originally adopted under
n 1395x(v)(1)(B), yet subsequently amended pur-
to a revamping of the reimbursement system for
letary hospitals, are not included within the purview
tion 1395oo(f)(2).

s, the district court erred in its interpretation of
ertinent statutory and regulatory authority. The
on of the district court is REVERSED, and RE-
DED with an instruction to award interest at the
f 10.583 percent.

SUNSHINE HEALTH SYSTEMS, INC.,
dba Christian Hospital Medical
Center, Plaintiff-Appellee,

v.

Otis BOWEN, Secretary of Health and
Human Services,*
Defendant-Appellant.

Nos. 85-6368, 86-6338.**

United States Court of Appeals,
Ninth Circuit.

Argued and Submitted Aug. 7, 1986.

Decided Feb. 6, 1987.

Medicare provider brought action challenging its being classified as "new hospital" during Prospective Payment System transition period, which resulted in its PPS reimbursement rate's being based on fixed standardized costs averages, without hospital-specific portion. The United States District Court for the Central District of California, Alicemarie H. Stotler, J., held invalid regulation under which provider was classified, and Secretary of Health and Human Services appealed. The Court of Appeals, Tang, Circuit Judge, held that: (1) provider did not need to await issuance of notice of provider reimbursement before appealing classification to Provider Re-

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*Otis Bowen is substituted for his predecessor, Margaret M. Heckler, Secretary of Health and Human Services, pursuant to Fed.R.App.P. 43(c)(1).

**Appellant's October 27, 1986 motion to consolidate appeal of the interest award (No. 86-6338) with appeal of the jurisdiction and statutory construction questions (No. 85-6368) and to waive filing of briefs is granted.

sement Review Board and, therefore, district court urisdiction over provider's claim; (2) regulation nating provider as "new hospital" if it did not have nth or longer cost reporting period ending before ic date conflicted with medicare statute and was and (3) provider was entitled to interest award.

rmed.

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mas J. Weiss, Los Angeles, Cal., for plaintiff-lee.

ward R. Cohen, Washington, D.C., for defendant-lant.

peal from the United States District Court for the al District of California.

fore TANG and BRUNETTI, Circuit Judges, and ESON,***District Judge.

NG, Circuit Judge:

Secretary of Health and Human Services (Secre- appeals from the district court's summary judgment ng that one of the Secretary's Medicare regulations valid. The district court held that 42 C.F.R. 71(a)(2) (1985) is inconsistent with 42 U.S.C. 5ww(b)(5) (1982) and that the Secretary's designa- f the Christian Hospital Medical Center, owned by ine Health Systems, Inc. (Sunshine), as a "new tal" for purposes of Medicare reimbursement was an of discretion.

Honorable William J. Jameson, Senior United States District District of Montana, siting by designation.

The Secretary contends that: (1) the district court lacked subject matter jurisdiction over Sunshine's action; (2) the disputed regulation is valid; and (3) the district court erred in awarding Sunshine interest on the judgment. We affirm the district court's judgment.

BACKGROUND

Title XVIII of the Social Security Act established the Federally funded health insurance program known as "Medicare." 42 U.S.C. §§ 1395-1395zz (1982 & Supp. II 1984). Until October 1, 1983, the Federal Government reimbursed eligible hospitals on a cost basis for providing covered services to Medicare beneficiaries. Under the cost-based system, which continues to apply to a limited class of providers, providing hospitals receive interim payments based on estimates of the hospitals' costs. 42 C.F.R. § 405.454(f)(1) (1985). A final determination of the actual reimbursable costs is not made until the end of the cost reporting year. A "Notice of Program Reimbursement" (NPR) contains the final determination, which is used to make a retroactive adjustment of the interim payments. 42 C.F.R. §§ 405.405-06, 404.453(f), 404.-454, 404.1803(a) (1985).

Congress amended 42 U.S.C. § 1395x in 1972 to grant explicit authority to the Secretary to exclude costs found to be unnecessary to the efficient delivery of needed services. *See* the Social Security Act Amendments of 1972, Pub.L. No. 92-603, § 223, 86 Stat. 1329, 1393; 42 U.S.C. §§ 1395f(b), 1395x(v)(1)(A) (1982). Regulations promulgatged under this so-called "section 223" authority placed limits on Medicare reimbursement for routine operating costs. *See generally* 42 C.F.R. § 405.460 (1985).

In the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub.L. No. 97-248, 96 Stat. 324, Con-

granted authority to the Secretary to establish new
on reasonable cost reimbursement. *See* 42 U.S.C.
5ww(b) (Supp. II 1984). The TEFRA provisions
ıded the coverage of the Section 223 limits and
cted the rate of increase of reimbursable inpatient
ting costs according to certain "target amounts."
enerally 42 C.F.R. § 405.463 (1985). By means of the
et amount," a hospital's per discharge operating
are limited by the allowable operating costs for the
ding 12-month cost reporting period plus an infla-
factor. 42 U.S.C. § 1395ww(b)(3). Hospitals whose
are less than their target amounts are entitled to
es, while hospitals whose costs exceed their target
nts are reimbursed only 25 percent of the excess
nt. 42 U.S.C. § 1395ww(b)(1) (Supp. II 1984).

1983, Congress amended the Social Security Act to
de for an entirely new method of computing pay-
s to Medicare providers. *See id.* § 1395ww(d). Under
ıew Prospective Payment System (PPS), payment
ıe operating costs of inpatient hospital services is
on the basis of prospectively determined rates and
ed on a per-discharge basis.[1] *Id.*; 42 C.F.R.
1(a) (1985).[2]

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all costs related to inpatient hospital services are covered by
PS. 42 U.S.C. § 1395ww(a)(4) (Supp. II 1984); 42 C.F.R.
(a) (1985). Moreover, certain types of hospitals, e.g. psychiat-
ldren's, and long-term care hospitals, are still reimbursed on a
able-cost basis. 42 U.S.C. § 1395ww(d)(1)(B) (Supp. II

prospectively determined rates are based on "diagnosis re-
groups" (DRGs). A DRG is a treatment category, a grouping
ilar kinds of cases whose cost of treatment is expected to be
. The Secretary assigns to each DRG "an appropriate weight-
ctor that reflects the estimated relative cost of hospital re-
s used with respect to discharges classified within that group

Congress established a transition period "to minimize disruptions that might otherwise occur because of a sudden change in reimbursement policy" from the cost-based system to the fixed payment system. H.R. Rep. No. 25, 98th Cong., 1st Sess. 132, *reprinted in* 1983 U.S. Code Cong. & Admin.News 143, 355. During this transition period, a hospital's payment for inpatient services is based on a blend of the Federal prospective payment rate[3] and a "hospital specific portion" (HSP). The HSP is based on a hospital's actual costs during a designated base year. 42 U.S.C. § 1395ww(d)(1)(A) (Supp. II 1984); 42 C.F.R. §§ 412.70-74 (1985). For the first year of the transition period (cost reporting periods beginning between October 1983 and October 1984), the HSP comprises 75 percent of the hospital's payment amount and the Federal portion comprises 25 percent. 42 U.S.C. § 1395ww(d)(1)(C)(i) (Supp. II 1984). Over the next four years,[4] the HSP portion is gradually decreased while the Federal portion is correspondingly increased. *Id.* § 1395ww(d)(1)(C)(ii)-(iii). After October 1987, the transition period ends and the Federal portion (*i.e.*, a

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compared to discharges classified within other groups." 42 C.F.R. § 412.60(b) (1985). The DRG weight is multiplied by a fixed national average cost of treating a Medicare patient to determine the hospital payment for treating a patient whose illness falls within that DRG. 42 U.S.C. § 1395ww(d)(3) (Supp. II 1984).

[3]The Federal prospective payment portion of the transition payment is based on the DRG weight multiplied by a shifting combination of regional and national averages; once the transition period ends, only national averages will be used. 42 U.S.C. § 1395ww(d)(1)(D) (Supp. II 1984); 20 C.F.R. § 412.70(c)(4) (1985).

[4] Originally designed to last three years, the transition period was recently extended to four years. 42 U.S.C. § 1395ww(d)(1) (Supp. II 1984), *amended by* Pub.L. No. 99-272, § 9102, 100 Stat. 82, 155 (1986).

national rate) comprises 100 percent of a hospital's ent amount. *Id.* § 1395ww(d)(1)(A)(iii) *amended by* Stat. 82, 155 (1986).

e Secretary's regulations provide that a hospital's year costs" are to be measured by periods of no less 12 months. 42 C.F.R. § 412.71(a)(2) (1985). If a tal is "newly participating in the Medicare program" does not have a 12-month cost reporting period g before September 30, 1983, the hospital is classis a "new hospital." 42 C.F.R. § 412.74(a)(1) (1985).

hospitals" are not accorded the benefit of any tal-specific portion (HSP) during the transition d. Payments to such providers are based solely on fixed Federal prospective payment rates. *Id.* .74(b).

e Medicare statutes establish an administrative approcedure, with disputes regarding provider pays to be heard by a Provider Reimbursement Review d (PRRB). *See* 42 U.S.C. § 1395*oo* (1982 & Supp. II .

FACTS

nshine Health Systems, Inc. (Sunshine) operates Christian Hospital Medical Center, a 36-bed acute hospital in Perris, California. In January 1981 the tal, then owned by Golden Triangle Medical Center, was decertified and closed due to high mortality In December 1981 Golden Triangle sold the hospi- Advanced Health Systems, Inc., which remodeled acility and had it recertified on March 10, 1982. nced Health Systems sold the hospital in June 1983 orizon Health Corporation which then sold it to hine in January 1984.

Because of the turnover, the last full 12-month cost eporting period for the hospital was January-December 980. Following recertification in 1982, the hospital filed ost reports for the following periods: March-September 982 (7 months), October 1982-May 1983 (8 months), nd June 1983-January 1984 (8 months).

In May 1984, Sunshine sought an exemption from the ection 223 reasonable-cost limitations for the hospital's ost reporting periods since March 1982. 42 C.F.R. 405.460(e)(2) (1985) permits exemptions from the rea-onable cost limits for "new providers." A new provider is ne that has operated in the Medicare program, under resent and previous ownership, for less than three full ears. *Id.* In Junly 1984, the Secretary granted the "new rovider" exemption based on increased start-up costs sulting from the closure of the hospital for more than 14 onths and the adverse publicity surrounding the decer-fication. At the same time, the Secretary informed Sun-ine that beginning January 1984 its hospital would be imbursed as a "new hospital" during the PPS transition eriod and that "its PPS rate [would be] based solely on blend of the regional and national Federal rates with no ospital-specific portion included."

Sunshine attempted to appeal this "new hospital" des-nation. Sunshine requested a hearing before the Pro-der Reimbursement Review Board (PRRB) for a etermination that, pursuant to 42 U.S.C. § 1395*oo*(f)(1) Supp. II 1984),[5] the PRRB lacked authority to decide unshine's challenge to the validity of 42 C.F.R. 412.71(a) (requiring 12-month or longer reporting peri-

[5] Section 1395*oo*(f)(1) states that a provider otherwise entitled to hearing "may file a request for a determination by the Board of its thority to decide the question of law or regulations relevant to the atters in controversy."

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ne PRRB refused to accept Sunshine's request for ng and for expedited judicial review because no of Program Reimbursement (NPR) had been for the first PPS year. The PRRB based this n on HCFA Administrative Ruling, HCFAR 84-1.[7]

ebruary 1985, Sunshine filed a complaint in the court seeking injunctive and declaratory relief, g that the Secretary's designation of Sunshine as a ospital" for purposes of the PPS transition period l 42 U.S.C. § 1395ww(b)(5) (1982).[8] Sunshine ed a motion for a preliminary injunction, present- dence that the "new hospital" designation would e hospital approximately $2 million over the three- ansition period, and asserting that the hospital be unable to continue operations unless immediate as granted.

district court granted a preliminary injunction ng the PRRB's decision to deny Sunshine a hear- ordering the PRRB to determine whether it had ty to decide Sunshine's appeal of its "new hospi- tus. The PRRB ruled that it was without authority le whether the disputed regulation was invalid and l Sunshine's request for expedited judicial review.

PRRB must comply with all of the Secretary's regulations FA Rulings. 42 C.F.R. § 405.1867 (1985).

Health Care Financing Administration (HCFA) is the agency ed by the Secretary to administer the Medicare program. *See* . § 401.101(a) (1985).

n 1395ww(b)(5) provides that "[i]n the case of any hospi- g any cost reporting period of other than a 12-month period, etary shall determine the 12-month period which shall be purposes of this section."

Sunshine and the Secretary filed cross motions for summary judgment. On July 22, 1985, the district court granted summary judgment for Sunshine, holding that "[t]o the extent that 42 C.F.R. § 412.71(a)(2) fails to provide for the use of any other than a 12 month cost reporting period as a base year, it is inconsistent with 42 U.S.C. § 1395ww(b)(5)" and that the Secretary's designation of Sunshine's Christian Hospital Medical Center as a "new hospital" was arbitrary, capricious, and an abuse of discretion. The court found that the "new hospital" designation, and the resulting absence of any HSP, substantially affected Sunshine's reimbursement amounts for fiscal years 1984-86. The court ordered the Secretary to: (1) grant Sunshine a 12-month base year period for purposes of calculating the hospital-specific portion (HSP) of its transition-year PPS reimbursement formula; (2) include the appropriate HSP in the PPS recalculations for 1985-86; and (3) recalculate the 1984 reimbursement and pay Sunshine the difference after factoring the appropriate HSP into the calculation.

ANALYSIS

I

Standard of Review

We review the district court's grant of summary judgment de novo. *Vance v. Hegstrom,* 793 F.2d 1018, 1022 (9th Cir. 1986); *Regents of the University of California v. Heckler,* 771 F.2d 1182, 1187 (9th Cir.1985).

[1] "Judicial review of Medicare reimbursement decisions is governed by the Administrative Procedure Act, 5 U.S.C. §§ 701-06 (1982), which requires a court to set aside agency actions found to be 'arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with

aw . . .' *Id.* at § 706." *Regents,* 771 F.2d at 1187. ugh an agency's interpretation of the statutory e under which it operates is entitled to considerable ence, we must reject an agency's interpretation that onsistent with the statute's meaning. *Vance,* 793 at 1023; *Regents,* 771 F.2d at 1187.

II

Jurisdiction

The Secretary contends that the district court l jurisdiction over this action because Sunshine's l to the PRRB was premature. This contention is on the Secretary's ruling HCFAR 84-1. Sunshine ts the validity of this ruling. Sunshine's contention erit.

h parties agree that at some point Sunshine may t its "new hospital" designation. Both parties agree Sunshine must first appeal to the PRRB, whose on is then subject to judicial review. At issue is er Sunshine appealed to the PRRB too soon. The tary contends that Sunshine could not appeal to the B until an NPR was issued. If so, then the district should have dismissed Sunshine's action for lack of iction.

1983 Medicare amendments altered the manner in hospitals could appeal payment amount disputes to RRB. 42 U.S.C. § 1395oo(a) (Supp. II 1984) pro- that "any hospital which receives payments in nts computed under subsection (b) or (d) of section w" may obtain a hearing by the PRRB if it "is isfied with a final determination of the Secretary as amount of the payment" and it requests a hearing days after notice of the Secretary's final determina-

on." In May 1984, the Secretary issued HCFAR 84-1, hich held that issues related to payment amounts under e PPS could not be appealed to the PRRB until the spital seeking appeal had received its NPR for the PPS st reporting period involved. 49 Fed.Reg. 22,413, 22,415 1984). The PRRB refused to hear Sunshine's appeal ecause no NPR had yet been issued for Sunshine's first PS cost year. The Secretary contends that HCFAR 84-1 an acceptable implementation of § 1395oo(a).

The district court disagreed with the Secretary's contention, concluding that:

> The statutory scheme formulated by Congress nowhere indicates that Congress intended that a Medicare provider must wait for review until an NPR for its first PPS year is issued before the PRRB will determine if it has authority to hear an appeal, particularly where the consequences of a delay in review may be immediate and drastic.

he Secretary's contention has also been rejected by a umber of district courts[9] and, most recently, by the ourt of Appeals for the D.C. Circuit in *Washington Iospital Center v. Bowen,* 795 F.2d 139 (D.C.Cir. 1986).

The D.C. Circuit's decision in *Washington Hospital enter* was based on an extensive, careful analysis of the

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[9] *See, e.g., St. Francis Hospital v. Heckler,* Medicare & Medicaid uide (CCH) ¶ 34,918 at 9516 (S.D.W.Va. Sept. 30, 1985); *Medical enter Hospital v. Heckler,* Medicare & Medicaid Guide (CCH) 34,920 at 9523-24 (M.D.Fla. Sept. 23, 1985); *Greenville Hospital ystem v. Heckler,* 642 F.Supp. 15, Medicare & Medicaid Guide CCH) ¶ 34,832 at 9174 (D.S.C.1985); *Doctors General Hospital, Inc. Heckler,* 613 F.Supp. 1036, 1041 (S.D.Fla.1985); *Redbud Hospital istrict v. Heckler,* Medicare & Medicaid Guide (CCH) ¶ 34,085 at 84 (N.D.Cal. July 30, 1984).

ges made to § 1395oo(a) by the 1983 amendments. nended, the statute provides as follows (the portions d in 1983 by Pub.L. 98-21 § 602(h)(1) are rlined):

Any provider of services which has filed a required ost report within the time specified in regulations nay obtain a hearing with respect to such cost report y a Provider Reimbursement Review Board . . . *and . . . any hospital which receives payments in amounts omputed under subsection (b) or (d) of section 1395ww of this title and which has submitted such eports within such time as the Secretary may require n order to make payment under such section may btain a hearing with respect to such payment by the Board,* if —

(1) such provider —

(A)(*i*) is dissatisfied with a final determination of the organization serving as its fiscal intermediary . . . as to the amount of total program reimbursement due the provider . . . , *or (ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title,* . . .

(2) the amount in controversy is $10,000 or more, and

uch provider files a request for a hearing within 180 after notice of the intermediary's final determination paragraph (1)(A)(i), *or with respect to appeals paragraph (a)(A)(ii), 180 days after notice of the tary's final determination* . . .

e D.C. Circuit concluded that § 1395oo(a) estab- two different appeal routes: one following the issu-

ance of an NPR (and relating to cost- based reimbursement) and the other following notice of what amount will be paid under the PPS. *Washington Hospital Center,* 795 F.2d at 145. The court reasoned that the language added to the introductory paragraph of § 1395oo(a) and the new subsection (1)(A)(ii) would be reduced to mere surplusage if the amendments had not been intended to create a new and different route for PPS appeals. *Id.* at 145-46. Regarding subsection (1)(A)(ii), the court stated: "The existing subsection on cost reimbursement appeals refers specifically to the NPR, which contains . . . determination 'as to the amount of total program reimbursement.' By adding subsection (1)(A)(ii), which contains no such reference to NPRs, Congress expressed its clear intention to change the prerequisites for PPS appeals." *Id.* at 146.

The court pointed out that under the PPS, the only variable factor in the final determination of a per-patient payment rate during the transition period is the hospital-specific portion (HSP). *Id.* at 147. The court reasoned that the differences in phrasing between subsection (1)(A)(i)'s appeal from "the amount of total program reimbursement" and subsection (1)(A)(ii)'s appeal from "the amount of the [PPS] payment" give "a clear signal that the statute refers to per-patient amounts rather than the overall figures contained in the NPR." *Id.* The court concluded (*id.* at 147-48 & n. 11):

> The amount of payment to hospitals during the PPS transition period is a weighted sum of a hospital-specific amount and a DRG amount, with the weights and the DRG amount fixed by statute or the Secretary. Thus, once there is a final determination as to the hospital-specific amount there is a final determi-

nation as to the amount of payment as required by § 1395oo(a)(1)(A)(ii).

* * *

[N]othing in the statute or legislative history supports the Secretary's position that he is authorized to impose an additional requirement of finality in the form of an NPR once the hospital's target amount has been set with finality pursuant to § 1395ww(d) and the implementing regulations.

the case at bar, the July 1984 letter stating that hine was not entitled to any hospital-specific portion ituted "notice of the Secretary's final determina-[10] as to the amount of PPS transition payments se it guaranteed that such payments would be calcu- solely on the basis of the fixed standardized cost ges.

e Secretary makes the same arguments here that apparently made in *Washington Hospital Center*. The tary argues that § 1395oo(a), as amended, retains xisting procedures which only allow appeal from the amount actually paid the hospital, an amount that is own until the hospital's cost reports have been sub- d and an NPR has been issued. The D.C. Circuit's sis in *Washington Hospital Center* is more asive.

e Secretary cites *Charter Medical Corp. v. Bowen*, 788 728 (11th Cir. 1986), as a case holding that the nce of an NPR is a prerequisite to filing an appeal. he court there held only that an NPR was required n appeal pursuant to 42 U.S.C. § 1395oo(a)(1)(A)

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rsuant to 42 U.S.C. § 1395oo(a)(3).

); the court did not reach the issue of whether an NPR required for a § 1395oo(a)(1)(A)(ii) appeal because he plaintiffs only appealed under subsection (A)(i). *harter Medical Corp.*, 788 F.2d at 733. The court did say, owever, that "§ 1395oo(a)(1)(A)(i) and (ii) appear to et up two different avenues of appeal for hospitals eceiving medicare payments." *Id.* at 732 (dicta). The ecision in *Charter Medical Group* is, therefore, entirely onsonant with the decision in *Washington Hospital enter.*

The Secretary also argues that the 1983 amendment of 1395oo(a) could not have made any substantive changes the review process because it was intended to be merely conforming amendment. Responding to the same argument, the *Washington Hospital Center* court stated: Under PPS, hospitals receive prospectively established ayments rather than retrospectively established reimursements. Under our reading of the statutory language, 1395oo(a) simply conforms the PRRB review process to is change in the method of calculating Medicare payents." *Washington Hospital Center,* 795 F.2d at 149. The ecretary cites Congressional language to the effect that [i]n general, the same conditions, which now apply for eview by the PRRB and the courts, would continue to pply." H.R.Rep. No. 25 at 143, *reprinted in* 1983 .S.Code Cong. & Admin.News at 362. The D.C. Circuit ointed out that "in general" implies that "in particular" here would be some changes. *Washington Hospital Center,* 95 F.2d at 149.

We adopt the reasoning of the D.C. Circuit and sustain he district court's ruling that Sunshine did not need to wait the issuance of an NPR before appealing to the RRB. Therefore, the district court had jurisdiction over

hine's claim that it should not have been designated
ew hospital."

III

Validity of 42 C.F.R. 412.71(a)(2)

] 42 C.F.R. § 412.71(a)(2) (1985), in conjunction
42 C.F.R. § 412.74(a)(1) (1985), provides that in
to avoid being designated a "new hospital," a
ital must have had a 12-month or longer cost report-
eriod ending before September 30, 1983. The district
declared § 412.71(a)(2) invalid on the ground that
nflicted with 42 U.S.C. § 1395ww(b)(5) (1982),
n directs the Secretary to select a 12-month cost
ting period for those hospitals that did not have one.

e Secretary argues that: (1) the regulation was
ly enacted pursuant to statutory directive;
1395ww(b)(5) does not apply to the computation of
der payments under the PPS; (3) the district court
by not deferring to the Secretary's statutory inter-
tion; and (4) allowing Sunshine a base year of less
12 continuous months permitted Sunshine to reap an
served windfall in its Medicare reimbursement. None
e Secretary's arguments are persuasive.

Consistency with Statutory Authority

nen Congress enacted the PPS legislation, it foresaw
the transition period would not eliminate the disrup-
caused by the shift from cost-based to fixed-payment
ursement for all providers. The House Committee
ays and Means stated:

Your Committee understands that there will be a
relatively small number of hospitals for which there
s no historical cost experience on which to base a

> target rate; for example, new hospitals. In this case, your Committee expects the Secretary to make appropriate provision for applying a prospective payment rate. This might be accomplished by using the total cost limit appropriate to the hospital as the hospital-specific portion of the payment due the hospital during a transition year.

H.R.Rep. No. 25 at 137, *reprinted in* 1983 U.S. Code Cong. & Admin.News at 356.

The Secretary's regulations provide that during the transition period a "new hospital" is one that is newly participating in the Medicare program and does not have a 12-month cost reporting period ending before September 30, 1983. 42 C.F.R. § 412-74(a)(1) (1985). Calculation of the 12-month period is determined by 42 C.F.R. § 412.71(a)(2) (1985), which provides:

> If the hospital's last cost reporting period ending before September 30, 1983 is for less than 12 months, *the base period will be the hospital's most recent 12-month or longer cost reporting period* ending before such short reporting period, with an appropriate adjustment for inflation. (The rules applicable to new hospitals are set forth in § 412.74). (emphasis added)

It was this regulation that directed a finding that Sunshine was a "new hospital" under § 412.74, because Sunshine did not have a 12-month or longer cost reporting period since the hospital reopened in March 1982. Once designated a "new hospital," the regulations provided that no part of the PPS transition payments will be based on Sunshine's actual costs:

> For purposes of computing transition payment rates for a new hospital, HCFA will not use the

nospital-specific portion of the prospective payment rate. Payments to new providers will be based solely on the Federal regional and national prospective payment rates, as described in § 412.70(d).

.F.R. § 412.74(b) (1985).

ence, it appears that the Secretary did not properly out the Congressional mandate in that the Secre- (1) rejected the suggestion to use an average cost to give an HSP to new hospitals, and (2) did not ne the "new hospital" designation to hospitals having istorical cost experience.

Application of § 1395ww(b)(5) to PPS

e district court found that § 412.71(a)(2) (1985) icted with 42 U.S.C. § 1395ww(b)(5) (1982), which s: "In the case of any hospital having any cost rting period of other than a 12-month period, the etary shall determine the 12-month period which be used for purposes of this section." The district t held that § 1395ww(b)(5) "governs the computa- of payment under the PPS" and that the Secretary d to comply with this statute when he used 2.71(a)(2) to deny Sunshine any hospital-specific ion for the PPS transition period.

e Secretary argues that § 1395ww(b)(5) does not y to payments under the PPS. This argument is ntly incorrect. First, § 1395ww(b)(5) refers to "the onth period which shall be used *for purposes of this on*" (emphasis added). "This section" clearly refers 1395ww, of which both (b) and (d) are subsections.

econd, although the PPS is basically embodied within .S.C. § 1395ww(d) (Supp. II 1984), there is a clear face between § 1395ww subsections (b) and (d).

Subsections 1395ww(d)(1)(A)(i) and (ii) set out the method for computing PPS payments during the transition period. One of the computational factors is "the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A) of this section)." 42 U.S.C. § 1395ww(d)(1)(A)(i)(I) and (ii)(I) (Supp. II 1984). Section 1395ww(b)(3)(A) (1982) defines the "target amount" as, in part, "the allowable operating costs of inpatient hospital services . . . recognized under this subchapter for such hospital for the preceding 12-month cost reporting period." The Secretary concedes that § 1395ww(b)(3)(A) is used in calculating PPS payments. The Secretary gives no reasonable argument for concluding that while subsection (b)(3) applies to the PPS, subsection (b)(5) does not.

The Secretary argues that § 1395ww(b)(5) applies only to the 1982 TEFRA amendments and is inapplicable to the PPS because Congress intended the subsequently enacted § 1395ww(d) to govern payments under PPS. This argument is unpersuasive because subsection (d) by its own terms incorporates one of the main concepts of subsection (b), as we have just noted.

C. *Deference to Agency's Interpretation*

The Secretary argues that the district court should have deferred to the Secretary's interpretation of the legislative scheme. This argument has no merit because the Secretary's interpretation is plainly at odds with the statutory scheme. *See Vance v. Hegstrom,* 793 F.2d 1018, 1023 (9th Cir.1986); *Regents of the University of California v. Heckler,* 771 F.2d 1182, 1187 (9th Cir.1985).

Prevention of Windfall

e Secretary argues that permitting Sunshine a hospi-
ecific portion for the transitional PPS payments
d result in an unfair windfall. The crux of this
ment is that Sunshine sought, and was granted, an
ption from the section 223 reasonable cost limits,
uant to 42 C.F.R. § 405.460(e)(2) (1985), as a "new
der." The "new provider" exemption was granted
use Sunshine has unusually high start-up costs due to
ospital's decertification, closure and bad publicity.
e its costs during the 1982-84 period were unusually
granting Sunshine a hospital-specific portion based
at period would result in Sunshine's receiving in-
d payments during the transition period.

nshine argues that its "new provider" status under
.460(e)(2) applied only to the former cost-based
bursement system, and has no relevance to whether it
ld be designated a "new hospital" under the PPS.
hine correctly points out that the definitions of a
provider" under § 405.460(e)(2) and a "new hospi-
under § 412.74 are different, and that a "new pro-
" is not necessarily also a "new hospital." The
ict court concluded that under the statutory scheme
new provider" exemption was not related to the 12-
h base period required for PPS reimbursement. We
e.[11]

---

t appears that Congress may have foreseen this windfall prob-
There is language in the legislative history that suggests that the
was to be based on a hospital's historical costs with the section
mits applied, but without any of the section 223 exemptions
as the "new provider" exemption) applied. *See* H.R. Rep. No.
136-37, *reprinted in* 1983 U.S. Code Cong. & Admin.News at
6. Hence, Congress seems to have intended that a "new pro-
" such as Sunshine would get an HSP component in its PPS

The Secretary's regulation 42 C.F.R. § 412.71(a)(2) (1985) conflicts with the plain meaning of 42 U.S.C. § 1395ww(b)(5) (1982), and the regulation is therefore invalid.

IV

Interest Award

[4] In May 1986, after the Secretary filed notice of appeal in this matter, Sunshine filed a Fed.R.Civ.P. 60(b) motion in the district court to require the Secretary to pay interest on the judgment pursuant to 42 U.S.C. § 1395*oo*(f)(2). Following our grant of a limited remand, the district court granted Sunshine's motion. The Secretary contends that the district court erred in awarding interest. This contention is without merit.

Section 1395*oo*(f)(2) provides that "the amount in controversy shall be subject to annual interest beginning . . after the 180-day period as determined pursuant to subsection (a)(3)." 42 U.S.C. § 1395*oo*(a)(3) defines this period as "180 days after notice of the Secretary's final determination." The Secretary argues that there is no "final determination" until a Notice of Program Reimbursement (NPR) is issued. This argument is identical to the Secretary's argument that the district court lacked subject matter jurisdiction in this case. We have already rejected that argument.

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transition payments, but that this HSP component would not include such unusual operating costs as would warrant a section 223 exemption. The Secretary, however, promulgated regulations whereby a provider in Sunshine's position, with no 12-month or longer cost reporting period before September 1983, was denied any base-year and thus denied any HSP in the calculation of its PPS transition payments.

Secretary also argues that interest should not be ed because nothing of value was withheld or d. The district court's judgment, however, ordered ecretary to pay "the sum equal to the difference en what plaintiff already received as PPS reim- nent for 1984 and what plaintiff is entitled to given oper hospital-specific element in its reimbursement la." Clearly the district court found that the Secre- had withheld payment amounts properly due ine.

CONCLUSION

find no grounds for reversal in any of appellant's ntions. The judgment is AFFIRMED.

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

SUNSHINE HEALTH SYSTEMS, INC.
dba Christian Hospital Medical Center,
Plaintiff-Appellee,

v.

OTIS R. BOWEN, Secretary of the Department of Health and Human Services,
Defendant-Appellant.

No. 87-6065

D.C. No. CV-85-0953-AHS
(C.D. Cal.)

ORDER

Cathy A. Catterson, Clerk
U.S. Court of Appeals

Filed: May 19, 1988

Before: ALARCON, FERGUSON, and BEEZER, Circuit Judges

Upon due consideration, (1) the petition for rehearing and (2) the motion by the American Hospital Association to file an amicus curiae brief are

DENIED.

A TRUE COPY
ATTEST MAY 26, 1988
CATHY A. CATTERSON
Clerk of Court

by: R. CALDWELL
Deputy Clerk

SC 1395(x)(v)(1)(B)

) Such regulations in the case of extended care ces furnished by proprietary facilities shall include sion for specific recognition of a reasonable return quity capital, including necessary working capital, ted in the facility and used in the furnishing of such ces, in lieu of other allowances to the extent that they ct similar items. The rate of return recognized pursuo the preceding sentence for determining the reason- cost of any services furnished in any fiscal period not exceed one and one-half times the average of the s of interest, for each of the months any part of which cluded in such fiscal period, on obligations issued for hase by the Federal Hospital Insurance Trust Fund.

JSC 1395(00)(f)

Finality of decision; judicial review; determinations Board authority; jurisdiction; venue; interest on nount in controversy

1) A decision of the Board shall be final unless the retary, on his own motion, and within 60 days after the ider of services is notified of the Board's decision, rses, affirms, or modifies the Board's decision. Provs shall have the right to obtain judicial review of any decision of the Board, or of any reversal, affirmance, nodification by the Secretary, by a civil action comced within 60 days of the date on which notice of any decision by the Board or of any reversal, affirmance, nodification by the Secretary is received. Providers l also have the right to obtain judicial review of any on of the fiscal intermediary which involves a question aw or regulations relevant to the matters in controy whenever the Board determines (on its own motion t the request of a provider of services as described in

the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which such determination is rendered. If a provider of services may obtain a hearing under subsection (a) of this section and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of Title 5, notwithstanding any other provisions in section 405 of this title. Any appeal to the Board or action for judicial review by providers which are under common ownership or control must be brought by such providers as a group with respect to any matter involving an issue common to such providers.

(2) Where a provider seeks judicial review pursuant to paragraph (1), the amount in controversy shall be subject to annual interest beginning on the first day of the first

.th beginning after the 180-day period as determined
suant to subsection (a)(3) of this section and equal to
rate of return on equity capital established by regula-
pursuant to section 1395x(v)(1)(B) of this title and
ffect at the time of the civil action authorized under
agraph (1) is commenced, to be awarded by the review-
court in favor of the prevailing party.

3) No interest awarded pursuant to paragraph (2)
ll be deemed income or cost for the purposes of
ermining reimbursement due providers under this
pter.

C.F.R. § 413.157

[¶ 20,887.157]

13.157 Return on equity capital of proprietary roviders.

(a) *Definitions*

For purposes of this section —

Proprietary provider" means a provider that is organ-
d and operated with the expectation of earning a profit
its owners (as distinguished from a provider that is
anized and operated on a nonprofit basis). Proprietary
viders may be sole proprietorships, partnerships, or
porations. Effective for cost reporting periods begin-
g on or after July 6, 1987, the term applies only to
prietary hospitals and SNFs.

(b) *General rule.* A reasonable return on equity capi-
invested and used in the provision of patient care is
d as an allowance in addition to the reasonable cost of
ered services furnished to beneficiaries by proprietary
viders.

(1) *Rate of return applicable to proprietary providers cost reporting periods beginning before July 6,*

987. Except as provided in paragraphs (b)(2), (b)(3), nd (b)(4) of this section, the amount allowable on an nnual basis, for cost reporting periods beginning before uly 6, 1987, is determined by multiplying the provider's quity capital by a percentage equal to one and one-half imes the average of the rates of interest on special issues f public debt obligations issued for purchase by the Iedicare Part A Trust Fund for each of the months uring the provider's reporting period or portion thereof overed under the program.

(2) *Rate of return for inpatient hospital services fur-ished by proprietary hospitals.* The rate used in deter-ining the return for inpatient hospital services is a ercentage of the average of the rates of interest de-cribed in paragraph (b)(1) of this section. The percent-ges applicable to inpatient hospital services are as ollows:

(i) 150 percent for cost reporting periods beginning efore April 20, 1983.

(ii) 100 percent for cost reporting periods beginning n or after April 20, 1983 and before October 1, 1986.

(iii) 75 percent for cost reporting periods beginning on r after October 1, 1986 and before October 1, 1987.

(iv) 50 percent for cost reporting periods beginning on r after October 1, 1987 and before October 1, 1988.

(v) 25 percent for cost reporting periods beginning on r after October 1, 1988 and before October 1, 1989.

(vi) Zero percent for cost reporting periods beginning n or after October 1, 1989.

(3) *Rate of return related to proprietary SNFs.* For ost reporting periods beginning on or after October 1, 985, the rate used in determining the return for SNF's is

percentage equal to the average of the rates of interest scribed in paragraph (b)(1) of this section.

(4) *Rate of return related to outpatient hospital services.* (i) For cost reporting periods beginning on or ter October 1, 1985, the rate used in determining the urn for outpatient hospital services furnished before nuary 1, 1988 is a percentage equal to the average of e rates of interest described in paragraph (b)(1) of this tion.

(ii) There is no allowance for return for outpatient spital services furnished on or after January 1, 1988.

(5) *Rate of return for proprietary service of all nonhospal and non-SNF providers.*

(i) For cost reporting periods beginning on or after tober 1, 1985, but before July 6, 1987, the rate used in termining the return for services of all nonhospital and n-SNF providers is a percentage equal to the average of e rates of interest described in paragraph (b)(1) of this tion.

(ii) For cost reporting periods beginning on or after ly 6, 1987, there is no allowance for return on equity pital for nonhospital and non-SNF providers.

(c) *Application* — (1) *Computation of equity capi-* For purposes of computing the allowable return, the ovider's equity capital means —

(i) The provider's investment in plant, property, and uipment related to patient care (net of depreciation) d funds deposited by a provider who leases plant, operty, or equipment related to patient care and is quired by the terms of the lease to deposit such funds et of noncurrent debt related to such investment or posited funds); and

(ii) Net working capital maintained for necessary and oper operation of patient care activities. However, debt presenting loans from partners, stockholders, or related ganizations on which interest payments would be allowle as costs but for the provisions of § 413.153(b)(3)), is not subtracted in computing the amount of equity pital in order that the proceeds from such loans be eated as part of the provider's equity capital. In computg the amount of equity capital upon which a return is owable, investment in facilities is recognized on the sis of the historical cost or other basis, used for depreation and other purposes under Part A of Medicare.

(2) *Acquisitions after July 1970.* With respect to a cility or any tangible assets of a facility acquired on or ter August 1, 1970, the excess of the price paid for such cility or such tangible assets over the historical cost as fined in § 413.134(b), or the cost basis, as determined der § 413.134(g) (whichever is appropriate), is not cludable in equity capital, and loans made to finance ch excess portion of the cost of such acquisitions (see 413.153(d)) are excluded in computing equity capital.

(3) *Acquisitions prior to August 1970.* With respect to facility or any tangible assets of a facility acquired fore August 1970, the excess of the price paid for such cility or assets over the fair market value of tangible sets at the time of purchase is includable in equity pital to the extent that it is reasonable except that the mulative allowable return for such excess may not ceed 100 percent of such excess. For purposes of this ction, the cumulative allowable return means the sum of e allowable rate of return on equity capital for all onths starting from August 1, 1970. For example, if the owable rates of return on equity capital for a provider e 9 percent for the first year (and such year started

gust 1, 1970), 8.5 percent for the second year, and 10.5 rcent for the third year, the cumulative allowable re- n at the end of the third year would be 28 percent. er the cumulative allowable return equals 100 percent, inclusion in equity capital of the excess shall no ger be allowable.

(4) *Computation of return of equity capital.* For pur- es of computing the allowable return, the amount of ity capital is the average investment during the re- ting period. The rate of return allowed, as derived m time to time based upon interest rates in accordance h this principle, is determined by HCFA and communi- ed through intermediaries. Return on investment as an ment of allowable costs is subject to apportionment in same manner as other elements of allowable costs.

Example of calculation of cumulative allowable return. urchased a provider on July 1, 1969, paying $100,000 excess of the fair market value of the assets acquired. vider X files its cost report on a calendar-year basis. e allowable rate of return on equity capital for August 970 — December 31, 1970 (4.538 percent), is obtained multiplying the allowable rate of return for the period ling December 31, 1970 (10.891) by 5/12 (a fraction of ch the numerator is the number of months from gust 1, 1970, to the end of the cost-reporting period l the denominator is the number of months in the cost- orting period). The cumulative allowable return for

ovider X for the period August 1, 1970 — December 31, 73 (32.367 percent) is computed as follows:

Cost reporting year ending:	Rate of return on equity capital (percent)
Dec. 31, 1970	4,538
Dec. 31, 1971	8,969
Dec. 31, 1972	8,891
Dec. 31, 1973	9,969
Total	32,367

(The $100,000 paid in excess of the fair market value of ıe assets acquired is included in equity capital until the ım of the allowable rate of return on equity capital equal 100 percent. Of course, no portion of the $100,000 may e amortized as an allowable cost or is otherwise allowa-le for any program reimbursement purposes other than or determining the provider's equity capital.)

(5) *Unapproved capital expenditures.* Effective with espect to any capital expenditure, the obligation for hich is incured after December 31, 1972, or after the ffective date of an agreement executed between a State nd the Secretary pursuant to section 1122 of the Act, hichever date is later (and subject to the exceptions in 413.161(c)), a provider's investment in plant, property, nd equipment related to patient care, and funds depos-ed by a provider which leases plant, property, or equip-ent related to patient care which are found to be xpenditures which have not been submitted to the desig-ated planning agency as required to have been deter-ined to be inconsistent with health facility planning equirements (as described in §§ 100.101 through 100.109 f this title) are not included in the provider's equity apital for computing the allowance for a reasonable eturn on equity capital.

PROOF OF SERVICE BY MAIL

m a citizen of the United States and a resident of the
y and County of Los Angeles; I am over the age of
hteen years and not a party to the within action; my
siness address is: 1706 Maple Avenue, Los Angeles,
lifornia.

August 16, 1988, I served the within Petition for Writ
Certiorari in re: "Sunshine Health Systems, Inc. vs.
is R. Bowen" in the United States Supreme Court,
tober Term 1988, No. 88.....;

the Parties in said action, by placing Three copies
ereof enclosed in a sealed envelope with postage fully
epaid, in the United States post office mail box at Los
geles, California, addressed as follows:

Ian Fan, Esq.
Assistant U.S. Attorney
1100 U.S. Courthouse
312 North Spring Street
Los Angeles, California 90012

Parties required to be served have been served.

I certify
true and

Execute

under penalty of perjury, that the foregoing is correct.

on August 16, 1988, at Los Angeles, California

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